**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**ADMINISTRATIVE HEARINGS FOR THE**
**DEPARTMENT OF HUMAN SERVICES**

**IN THE MATTER OF:**

[redacted]

Reg No.: 2011-51507
Issue No.: 2009
Case No.: [redacted]
Hearing Date: January 19, 2012
Macomb County DHS (20)

**ADMINISTRATIVE LAW JUDGE:** Colleen M. Mamelka

## HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a telephone hearing was conducted from Detroit, Michigan on Thursday, January 19, 2012. The Claimant appeared and testified. [redacted] appeared on behalf of the Department of Human Services ("Department").

## ISSUE

Whether the Department properly determined that the Claimant was no longer disabled for purposes of the Medical Assistance ("MA-P") benefit program?

## FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Claimant was a MA-P recipient with a review date of November 2009.

2. The Department did not review the Claimant's case until April 2011.

3. On May 12, 2011, the Medical Review Team ("MRT") found the Claimant not disabled. (Exhibit 2, pp. 1, 2)

4. On July 7, 2011, the Department sent a Notice of Case Action to the Claimant informing her that effective August 1, 2011, her MA-P benefits would close. (Exhibit 3)

5. On or about July 20, 2011, the Department received the Claimant's timely written request for hearing.

6. Despite the timely hearing request, the Department terminated the Claimant's coverage. (Exhibit 3)

7. On October 27, 2011, the State Hearing Review Team ("SHRT") found the Claimant not disabled.

8. The Claimant alleged physical disabling impairments due to fibroid cystic disease, degenerative disc disease, and back and neck pain with radiation and spasms.

9. The Claimant alleged mental disabling impairments due to bipolar disorder and post-traumatic stress disorder.

10. At the time of hearing, the Claimant was [redacted] years old with an [redacted] birth date; was 5'6" in height; and weighed approximately 160 pounds.

11. The Claimant has the equivalent of a high school education with an employment history power washing.

12. The Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

## CONCLUSIONS OF LAW

As a preliminary matter, the Claimant was previously approved for MA-P benefits with a review date in November 2009. The Department reviewed the case in April 2011 resulting in a MRT denial. At this point, instead of notifying the Claimant of the MRT determination and allowing the Claimant the right to appeal while keeping coverage active, the Department improperly terminated the Claimant's coverage. As directed, the Claimant submitted another application for MA-P benefits and filed for a hearing. In light of the foregoing, the analysis for this decision is that of a review, and not of a new application.

The Medical Assistance program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services, formerly known as the Family Independence Agency, pursuant to MCL 400.10 *et seq.* and MCL 400.105. Department policies are found in the Bridges Administrative Manual ("BAM"), the Bridges Eligibility Manual ("BEM"), and the Bridges Reference Tables ("RFT").

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

Once an individual has been found disabled for purposes of MA benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994. In evaluating a claim for ongoing MA benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding an individual's disability has ended, the department will develop, along with the Claimant's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking

continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The first step in the analysis in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a Listing is met, an individual's disability is found to continue with no further analysis required.

If the impairment(s) does not meet or equal a Listing, then Step 2 requires a determination of whether there has been medical improvement as defined in 20 CFR 416.994(b)(1); 20 CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i). If no medical improvement is found, and no exception applies (see listed exceptions below), then an individual's disability is found to continue. Conversely, if medical improvement is found, Step 3 calls for a determination of whether there has been an increase in the residual functional capacity ("RFC") based on the impairment(s) that were present at the time of the most favorable medical determination. 20 CFR 416.994(b)(5)(iii).

If medical improvement is not related to the ability to work, Step 4 evaluates whether any listed exception applies. 20 CFR 416.994(b)(5)(iv). If no exception is applicable, disability is found to continue. *Id.* If the medical improvement *is* related to an individual's ability to do work, then a determination of whether an individual's impairment(s) are severe is made. 20 CFR 416.994(b)(5)(iii), (v). If severe, an assessment of an individual's residual functional capacity to perform past work is made. 20 CFR 416.994(b)(5)(vi). If an individual can perform past relevant work, disability does not continue. *Id.* Similarly, when evidence establishes that the impairment(s) do (does) not significantly limit an individual's physical or mental abilities to do basic work activities, continuing disability will not be found. 20 CFR 416.994(b)(5)(v). Finally, if an individual is unable to perform past relevant work, vocational factors such as the individual's age, education, and past work experience are considered in determining whether despite the limitations an individual is able to perform other work. 20 CFR 416.994(b)(5)(vii). Disability ends if an individual is able to perform other work. *Id.*

The first group of exceptions (as mentioned above) to medical improvement (i.e., when disability can be found to have ended even though medical improvement has not occurred) found in 20 CFR 416.994(b)(3) are as follows:

(i) Substantial evidence shows that the individual is the beneficiary of advances in medical or vocational therapy or technology (related to the ability to work;
(ii) Substantial evidence shows that the individual has undergone vocational therapy related to the ability to work;
(iii) Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the impairment(s) is not as disabling as previously determined at the time of the most recent favorable decision;
(iv) Substantial evidence demonstrates that any prior disability decision was in error.

The second group of exceptions [20 CFR 416.994(b)(4)] to medical improvement are as follows:

(i) A prior determination was fraudulently obtained;
(ii) The individual failed to cooperate;
(iii) The individual cannot be located;
(iv) The prescribed treatment that was expected to restore the individual's ability to engage in substantial gainful activity was not followed.

If an exception from the second group listed above is applicable, a determination that the individual's disability has ended is made. 20 CFR 416.994(b)(5)(iv). The second group of exceptions to medical improvement may be considered at any point in the process. *Id.*

As discussed above, the first step in the sequential evaluation process to determine whether the Claimant's disability continues looks at the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1.

Based on the records, at the time of the Claimant's initial approval in 2009, the Claimant was diagnosed/treated with degenerative disc changes, scoliosis, disc protrusion/bulge, acute bronchitis, neck and back pain/spasms, arm pain at PICC line, breast abscess with surgery, rib strain, somatic dysfunction, chest pain, fibrocystic disease, bilateral breast discharge, and lumbar disc disease.

In support of his claim, a Medical Examination Report was completed on behalf of the Claimant. The current diagnoses were acute back pain with degeneration and cyst confirmed by an MRI. The Claimant's condition was deteriorating.

On [redacted] the Claimant's treating Psychologist wrote a letter confirming treatment from [redacted] with the diagnoses of cocaine dependency, alcohol dependency, and bipolar disorder. The Global Assessment Functioning ("GAF") was 45.

On [redacted] the Claimant's treating Physician wrote a letter confirming treatment/diagnoses of fibrocystic disease, deteriorating disc disease, and hyperlipidemia. The Physician emphasized the importance of the Claimant to remain on prescribed treatment.

In this case, it is unclear exactly on what the MRT approved the Claimant's disability. The Claimant continues to have the same diagnoses from the approval with additional serious conditions. Listing 1.00 (musculoskeletal system), Listing 4.00 (cardiovascular system), Listing 12.00 (mental disorders), and Listing 14.00 (autoimmune disorders) were reviewed in light of the objective medical evidence. Ultimately, it is found that the Claimant's impairments do not meet the intent and severity requirement of a listed impairment and, therefore, a determination of whether the Claimant's condition has medically improved is necessary.

As noted above, the Claimant was previously found disabled based on the diagnoses of degenerative disc changes, scoliosis, disc protrusion/bulge, acute bronchitis, neck and back pain/ spasms, arm pain at PICC line, breast abscess with surgery, rib strain, somatic dysfunction, chest pain, fibrocystic disease, bilateral breast discharge, and lumbar disc disease. In comparing those medical records to the recent evidence (as detailed above) and noting the Claimant's condition is deteriorating, it is found that the Claimant's condition has not medically improved. Instead, the Claimant suffers from the same conditions as well as additional impairments. Accordingly, the Claimant's disability is found to continue with no further analysis required.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law finds the Claimant disabled for purposes of the MA-P benefit program.

Accordingly, It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall, if not previously done so, activate MA-P coverage from the point of closure pending the processing of the review application.

3. The Department shall initiate processing of the April 2011 review application to determine if all other non-medical criteria are met and inform the Claimant of the determination in accordance with Department policy.

4. The Department shall supplement for any lost benefits (if any) that the Claimant was entitled to receive if otherwise eligible and qualified in accordance with Department policy.

5. The Department shall review the Claimant's continued eligibility in March 2013 in accordance with Department policy.

Colleen M. Mamelka

Colleen M. Mamelka
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: February 7, 2012

Date Mailed: February 7, 2012

**NOTICE:** Michigan Administrative Hearing System (MAHS) may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. MAHS will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request. (60 days for FAP cases)

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

Claimant may request a rehearing or reconsideration for the following reasons:

- A rehearing **MAY** be granted if there is newly discovered evidence that could affect the outcome of the original hearing decision.
- A reconsideration **MAY** be granted for any of the following reasons:
  - misapplication of manual policy or law in the hearing decision,
  - typographical errors, mathematical error, or other obvious errors in the hearing decision that effect the substantial rights of the claimant:
  - the failure of the ALJ to address other relevant issues in the hearing decision.

Request must be submitted through the local DHS office or directly to MAHS by mail at
Michigan Administrative Hearings
Re consideration/Rehearing Request
P. O. Box 30639
Lansing, Michigan 48909-07322

2011-51507/CMM

CMM/cl

cc: [redacted]